MEDDIC-MS Data Book

Medicaid Encounter Data Driven Improvement Core Measure Set

Vol. 1--2002 HMO Aggregate Performance Data Wisconsin Medicaid and BadgerCare Programs

Wisconsin Department of Health and Family Services
Division of Health Care Financing, Bureau of Managed Health Care Programs

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Volume 1: 2002 HMO Aggregate Performance Data
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Introduction and Background

Quality improvement pioneer W. Edwards Deming said, "You can't manage what you can't measure." His observation referring to data-driven quality improvement in manufacturing applies equally to health care.

In its 2002 book, ***Leadership by Example: Coordinating Government Roles in Improving Health Care Quality***, the Institute of Medicine (IOM) called for standardized, accurate, real-time performance measures for health care, particularly for publicly-funded programs. For example, it recommended:

- Measures "derived from computerized data and public reporting of comparative quality information."
- "Providers should not be burdened with reporting the same patient-specific performance data more than once to the same government agency."
- "Finally, effective performance measurement demands real-time access to sufficient clinical detail and accurate data. By the time retrospective performance measures reach decision-makers, it is too late for them to be useful. The current health information environment is far too fragmented, technologically primitive, and overly dependent on paper medical records."

In addition to being central to effective public health policy, as described by the Institute, standardized performance measures are required for all state Medicaid managed care programs by federal law. Specifically, 42 CFR §438.240(c) requires that states monitor health maintenance organization (HMO) performance using standardized performance measures and that HMOs submit data necessary for the performance measures to operate.

MEDDIC-MS (Medicaid Encounter Data Driven Improvement Core Measure Set) is Wisconsin's set of standardized performance measures for Medicaid and BadgerCare (the State Children's Health Insurance Program, SCHIP) managed care. Use of MEDDIC-MS was approved by the Centers for Medicare and Medicaid Services (CMS) as part of its review of the state's quality improvement strategy in August 2003. In October 2003, the Agency for Healthcare Research and Quality (AHRQ) recognized MEDDIC-MS for inclusion in the National Quality Measures Clearinghouse (NQMC®). To view the measure summaries on the NQMC, go to: http://www.qualitymeasures.ahrq.gov/resources/measureindex.aspx and scroll down to "State of Wisconsin."

MEDDIC-MS

The ***Medicaid Encounter Data Driven Improvement Core Measure Set***, is a new performance measurement system for Wisconsin's Medicaid and BadgerCare (SCHIP) HMO programs. It consists of two sets of measures; Targeted Performance Improvement Measures (TPIM), which focus on high priority areas identified by stakeholders and monitoring measures, most of which are utilization measures. The TPIMs are more detailed in structure than the monitoring measures, and include rationale, managed care reference data, and performance goals. They also include performance improvement requirements that apply when performance goals are not achieved.

Innovations in program-wide performance management include:

- ***Reporting:*** HMOs are no longer required to submit reports on performance measures. This allows participating HMOs to devote more resources to performance improvement initiatives and reduces administrative cost and complexity.
- ***Encounter data-driven measures:*** MEDDIC-MS is a fully automated system, utilizing HMO encounter data and other State-controlled electronic data sources. This significantly reduces costs associated with data acquisition and eliminates data contamination caused by inaccurate patient-supplied history. Medical record review continues to be used for data validity audits, ambulatory quality of care audits, and cases where HMOs wish to augment encounter data and special audit functions.
- ***Data extraction and measure calculation:*** The Department of Health and Family Services (DHFS) extracts data for each measure and calculates each HMO's performance on the measure through a third party data services vendor. This facilitates greater consistency, completeness and accuracy in calculation of the measures than having each HMO calculate its own rates.
- ***Customer/vendor relationship:*** Traditional managed care performance measurement allows each HMO (vendor) to report its own performance. MEDDIC-MS corrects this problem.
- ***Speed, relevance and trending:*** Measures can be calculated as needed and in time frames other than traditional calendar year reporting.
- ***Measure set flexibility:*** MEDDIC-MS can be adjusted quickly to meet changing program needs and to refine the measures.
- ***Accuracy:*** MEDDIC-MS specifications use validated encounter data and, in some measures, other state-controlled data sources such as lead screen and immunization data from the Division of Public Health.
- ***Performance improvement goals:*** Performance goal setting is designed to first establish baseline levels using MEDDIC-MS technical specifications and then through a collaborative process, establish realistic intermediate goals for subsequent years to "ramp up" program-wide performance on the TPIMs.

- ***Constancy of mission:*** MEDDIC-MS includes Targeted Performance Improvement Measure (TPIM) topics that have been in use for the past five years, but they have been modified to work in the automated encounter data environment and new topics have been added. The *monitoring measures* included in MEDDIC-MS are consistent with the topics used in the past and they have been modified to work in the encounter data environment.

MEDDIC-MS was developed with input and assistance from a variety of stakeholders. Testing and development of initial baseline rates on selected measures was completed in July 2002. The system was implemented for performance measurement program-wide between July and October 2003. The data in this booklet presents program-wide performance rates for all HMOs combined on all MEDDIC-MS performance measures based on CY 2002 data. For measures where CY 2000 data is available, the data is presented in side-by-side comparative charts.

Complete technical specifications for the MEDDIC-MS measures are available upon request. Contact: Gary R. Ilminen, RN at (608) 261-7839 or ILMINGR@DHFS.STATE.WI.US.

Care Analysis Projects

Since 2001, the Department has implemented an innovative program-wide proactive approach to performance improvement called Care Analysis Projects (CAP). Through CAP, enrollee-specific health care needs are identified and the data about those needs are shared with the enrollee's HMO. In this way, the Department seeks to assist in quality improvement by allowing HMOs and providers to focus outreach on individuals with unmet needs.

CAP focuses on several chronic conditions and on the provision of key preventive services. Chronic conditions included are congestive heart failure, asthma, and diabetes. Preventive health services include lead screening and prenatal risk assessment.

MEDDIC-MS and CAP work together. CAP provides data-driven targeted intervention and MEDDIC-MS allows accurate, real-time performance assessment.

HMO Performance Improvement Projects

Since the early 1990's the HMO contract has required HMOs to complete at least two performance improvement projects in each calendar year and submit reports about them to the Department annually. Analysis of those

reports by the Department's quality improvement staff revealed that between CY 1997 and CY 2000, 73 percent of HMO interventions on topics of performance improvement projects resulted in some degree of improvement.

Notes on Data in this report:
Data referred to in this report for CY 2000 represents encounter and other reporting data spanning the period from 7/1/2000 to 6/30/2001.

For five measures the CY 2000 data includes data from I-Care, a managed care organization serving individuals eligible for supplemental security income (SSI) in Milwaukee county. Those measures are asthma care, maternity care, mental health substance abuse follow-up care within 7 and 30 days, mental health substance abuse evaluations and outpatient care, and screening mammography. For CY 2002 and subsequent years, the I-Care performance data is reported separately using a special version of the measures called MEDDIC-MS SSI.

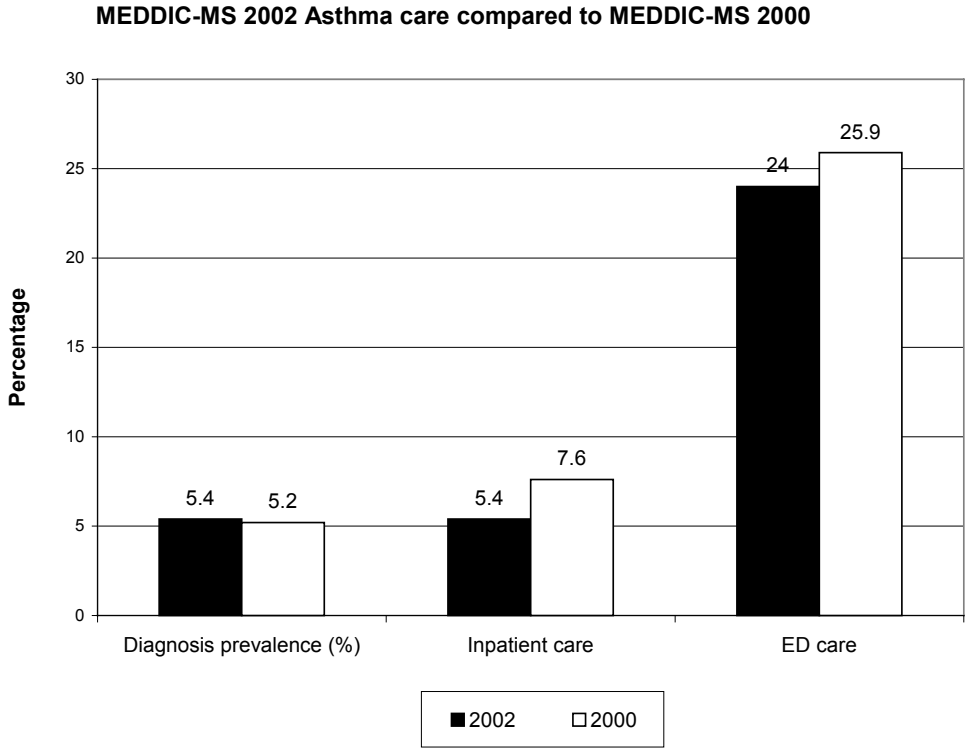
Results on Clinical Performance Measures

Asthma care

Monitoring measure

Asthma is a chronic respiratory condition affecting the lungs. People with asthma suffer episodes where airflow in and out of the lungs is reduced by constriction of the airways in the lungs and by excess mucous. Between 12 and 15 million Americans have asthma, including nearly 5 million children. Nationwide, in 1997, the disease caused 1.2 million emergency department (ED) visits, over 445, 000 hospital days and has been fatal in some cases.

Episodes of asthma can be reduced with effective management and patient education. For these reasons, early diagnosis, patient/parent education and medical management are crucial to prevention of exacerbation and maintenance of good quality of life.



Prevalence--the percentage of enrollees with the diagnosis of asthma--remained nearly the same in 2002 as in 2000. HMOs made progress in ambulatory care for this condition, with the utilization of both emergency department care and inpatient care declining. Use of ED care for asthma decreased from 25.9 percent in 2000 to 24 percent in 2002; use of inpatient care for asthma declined from 7.6 percent in 2000 to 5.4 percent in 2002.

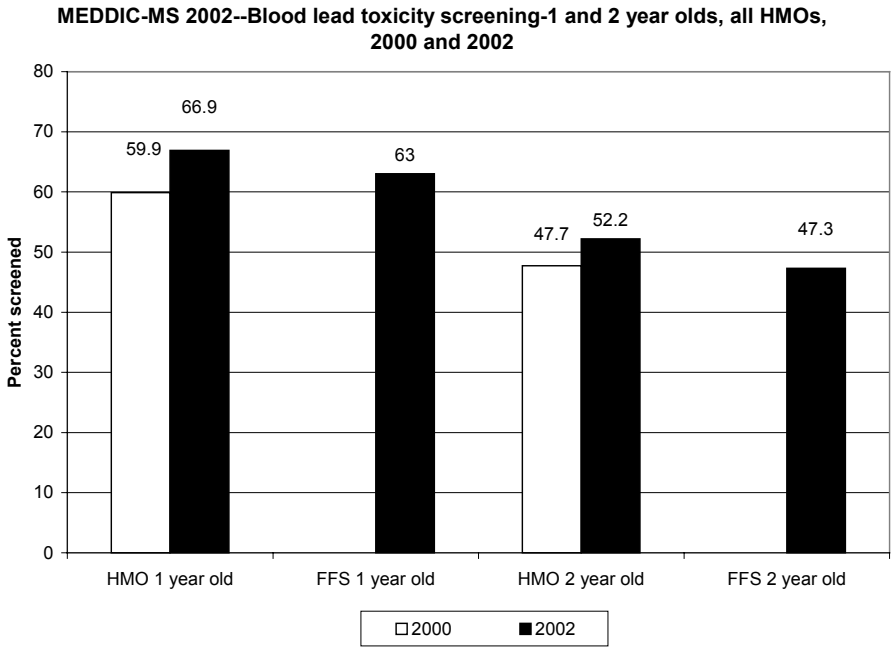
Progress may be the result of HMO disease management programs--9 of 13 HMOs responding to a recent survey of participating Medicaid/BadgerCare HMOs indicated they have asthma disease management programs in effect. In addition, 7 of 13 HMOs have conducted performance improvement projects on asthma care since 2000. Finally, the Department has operated a Care Analysis Project on asthma since 2001.

Blood lead toxicity screening

Targeted performance improvement measure

Children in Medicaid are considered to be at risk for exposure to sources of lead poisoning in their living environment. For this reason, provision of blood lead toxicity testing is required for children at age one and two years and up to age six if elevated levels or risk factors have been identified.

In the Wisconsin Medicaid & BadgerCare HMO program, blood lead toxicity screening at age one and two years is required under the contract and is a Targeted Performance Improvement Measure in the MEDDIC-MS performance measure system.



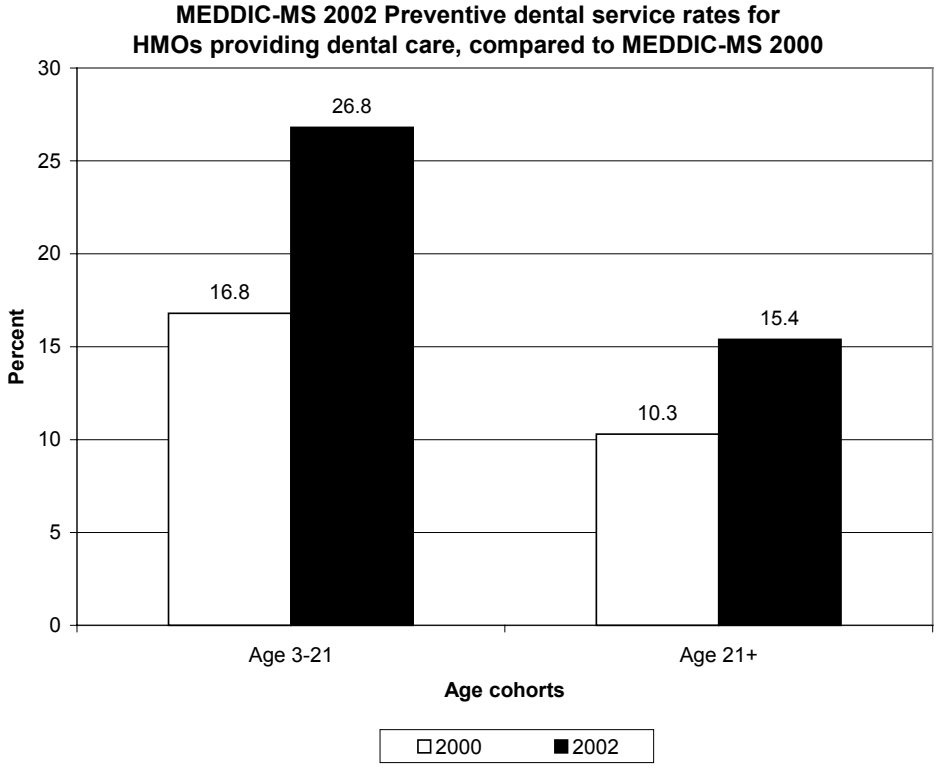
MEDDIC-MS technical specifications allow lead screening data from the Division of Public Health to be merged with HMO encounter data. This has improved data completeness and improved accuracy of performance measurement.

Blood lead toxicity screening rates improved between 2000 and 2002 for both one and two year old children. For comparison, 2002 fee-for-service (FFS) rates are shown on the chart, indicating that the lead toxicity screening rate is higher in managed care than in FFS for both age groups.

In 2001, the Department instituted the Care Analysis Project (CAP) on blood lead toxicity screening, whereby recipient-specific lead testing data is shared with the individual's HMO in an effort to assist HMOs with identification of children in need of lead screening. This facilitates outreach and follow-up for children who have not received screening and may be a significant factor in the recent improvement in the lead screening rates for children in both age groups. In addition, 4 of 13 Medicaid/BadgerCare HMOs have conducted performance improvement projects on lead screening since 2000.

Dental (preventive) services

Targeted performance improvement measure



Preventive dental services include initial and comprehensive dental examinations, prophylaxis, topical application of fluoride and application of sealants.

Dental care can prevent development of dental caries, tooth loss, oral infections, abscesses and other problems. Preventive dental services are of particular value soon after the eruption of teeth for in young children. Teeth generally first erupt between age 6 and 28 months and emerge enough to benefit from preventive care between 1 and 3 years.

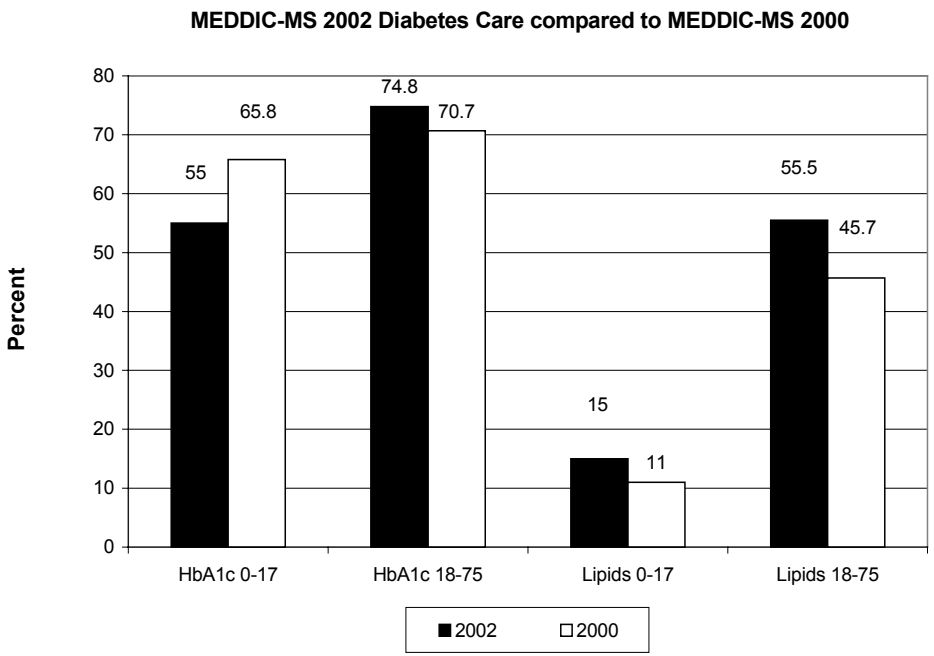
In 2002, three HMOs in the Milwaukee area of 13 participating in Medicaid/BadgerCare offered dental services. HMO enrollees in the rest of the state receive dental benefits on a fee-for-service basis; but 48.6 percent of all HMO enrollees receive dental benefits through their HMO.

Access to dental services has been a challenge in the Medicaid program for quite some time. Concerted efforts on the part of the Medicaid/BadgerCare HMOs to perform outreach to enrollees and to improve their dental provider networks appear to be contributing to improvements in this MEDDIC-MS dental service access indicator.

Improved completeness and accuracy of encounter data on dental preventive services is also a probable factor in the improvements evident from 2000 to 2002. Despite the apparent improvement in access indicated by higher utilization for both age groups, the overall percentage of enrollees receiving preventive dental services remains relatively low, suggesting that dental care remains a performance improvement opportunity.

Diabetes care

Targeted performance improvement measure



Diabetes mellitus is a chronic condition that can have devastating effects including heart disease, kidney damage and blindness.

Diabetes is a condition that is considered sensitive to ambulatory care. That is, serious consequences can be reduced or prevented with proper management.

Two important diabetes management tests are monitored in the MEDDIC-MS measure system.

One test is the hemoglobin A1c (HbA1c), which is a blood test that indicates the level of blood sugar control over time. The other test is the lipid profile, which is a blood test that monitors the levels of "fats" (lipids) in the blood stream. Though these tests do not allow definitive assessment of quality of life for diabetic individuals nor of total quality of care for diabetes, they do allow assessment of key indicators of diabetic management. The chart reflects the percentage of HMO enrollees diagnosed with diabetes who received the tests.

Ambulatory care for diabetes has improved overall. Lipid test rates increased from 45.7 percent for 18-75 year olds in 2000 to 55.5 percent in 2002 and HbA1c test rates increased from 70.7 percent for 18-75 year olds in 2000 to 74.8 percent in 2002. The HbA1c rate for 0-17 years of age declined from 65.8 percent in 2000 to 55.0 percent in 2002. Four HMOs have conducted performance improvement projects since 2000 and diabetes has been a Care Analysis Project topic since 2001. In addition, 11 of 13 HMOs have disease management programs for diabetes.

EPSDT (HealthCheck) comprehensive well-child exams

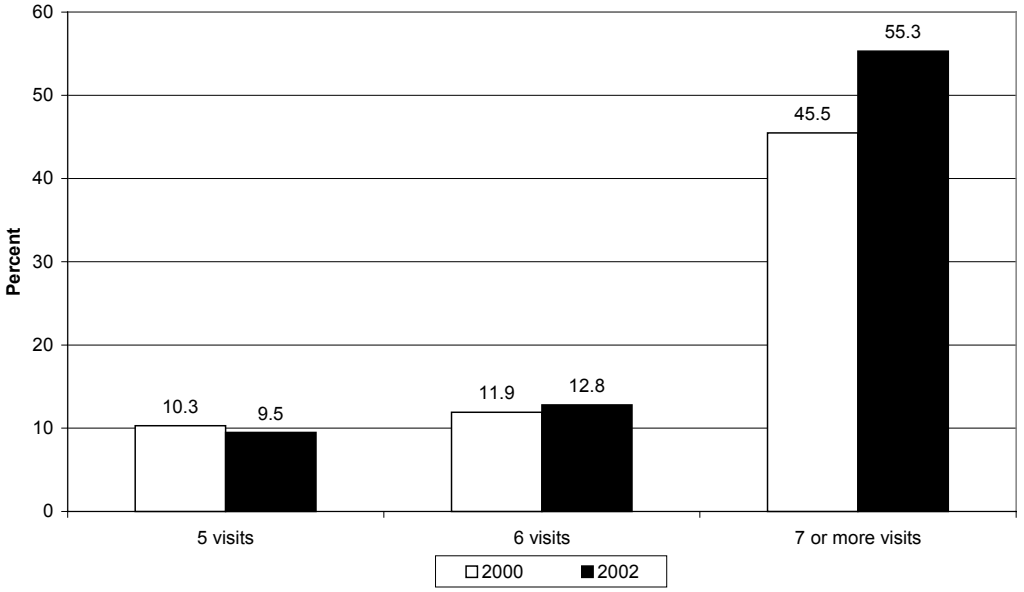
The federal mandate to state Medicaid programs includes provision of Early, Periodic Screening, Diagnosis and Treatment (EPSDT) services for children. Wisconsin's EPSDT services are called HealthCheck screens. HealthChecks include an unclothed physical exam, age appropriate immunizations, lab work, including blood lead toxicity tests, health and developmental history, vision and hearing tests, and oral assessment beginning at age 3.

Nine HealthCheck visits should be provided to each child by age two. Significant improvement has occurred in the percentage of children receiving 7 or more HealthCheck exams by age two years. However, since the number of visits has a direct bearing on completion of immunizations, lead screens and other preventive services, improvement in the delivery rate of HealthCheck screens remains a priority.

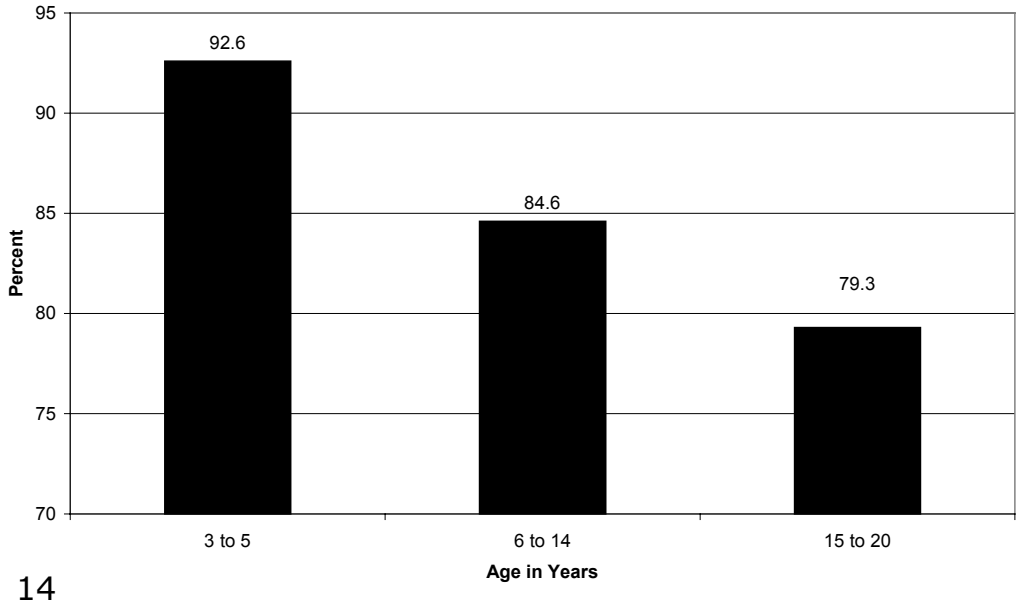
National data shows that older children receive EPSDT services less frequently. Wisconsin data exhibits a similar trend.

Eight of thirteen Medicaid/BadgerCare HMOs have conducted performance improvement projects on HealthCheck since 2000. Data for age group 3-20 years was not calculated in 2000.

MEDDIC-MS 2002 HealthCheck (EPSDT) visits-Children Age Two Years and Under Compared to MEDDIC-MS 2000



MEDDIC-MS 2002 Children with at least one HealthCheck in the Look-back Period, by Age



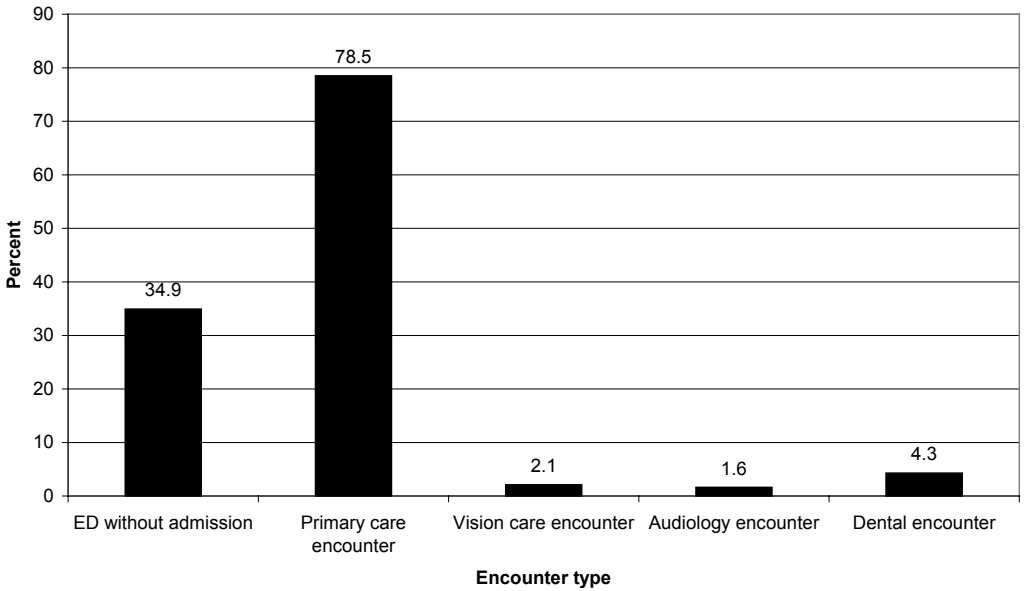
General and specialty care-outpatient

Monitoring measure

Access to outpatient or ambulatory care for a variety of health care needs is essential for overall health maintenance and improvement.

This MEDDIC-MS measure is designed to assess access to emergency care that does not result in subsequent hospitalization, access to primary care, to vision care, audiology services and dental care. The measure tracks what percentage of Medicaid and BadgerCare HMO enrollees had access to those services on at least one occasion during the look-back period.

MEDDIC-MS 2002 General & Specialty Care, Enrollees with at least one visit in the Look-back Period, by specialty, all ages

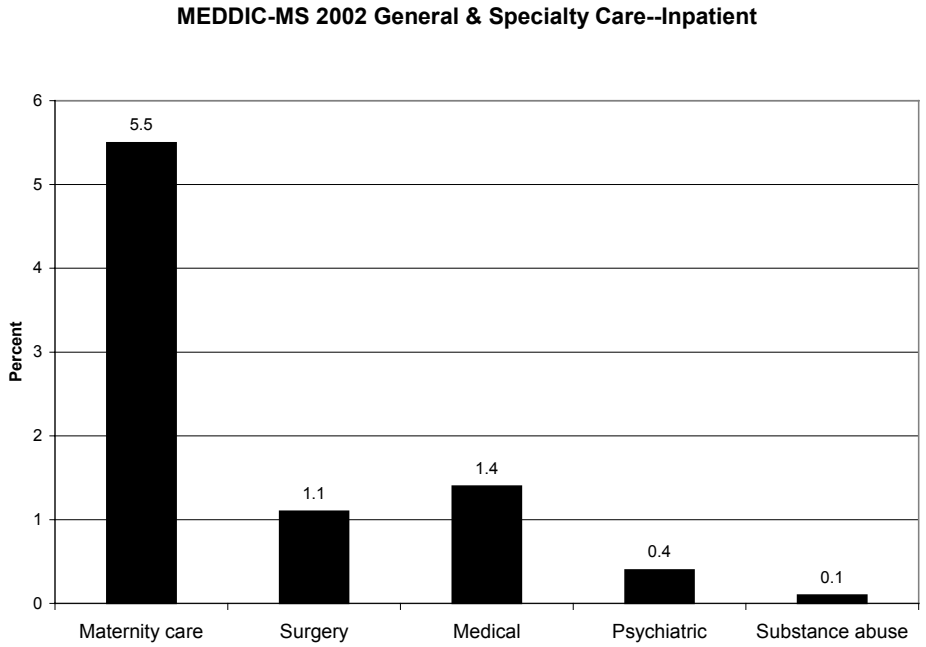


The chart displays the overall results for 2002, but does not have comparative data for 2000, as this measure was not calculated in 2000. The measure reveals that more than one-third of all HMO enrollees had at least one emergency department (ED) care encounter that did not result in subsequent hospitalization. It also shows that primary care access for enrollees of all ages was good, with nearly 8 out of every 10 HMO enrollees having at least one primary care encounter in the look-back period (calendar year 2002). The percentage of enrollees having access to vision and hearing services was relatively small. Further data analysis is necessary to determine whether that indicates a problem.

Dental encounters appear small in proportion also, but only 3 participating HMOs provide dental care under their contract with the Department. This dental measure generated a smaller percentage of enrollees receiving services than the preventive care measure, because the number of enrollees included in the denominator is larger for this measure. Improving access and utilization of dental services in Medicaid and BadgerCare remains a performance improvement opportunity. See also "Dental (preventive) care" on page 12 for further information.

General and specialty care-inpatient

Monitoring measure



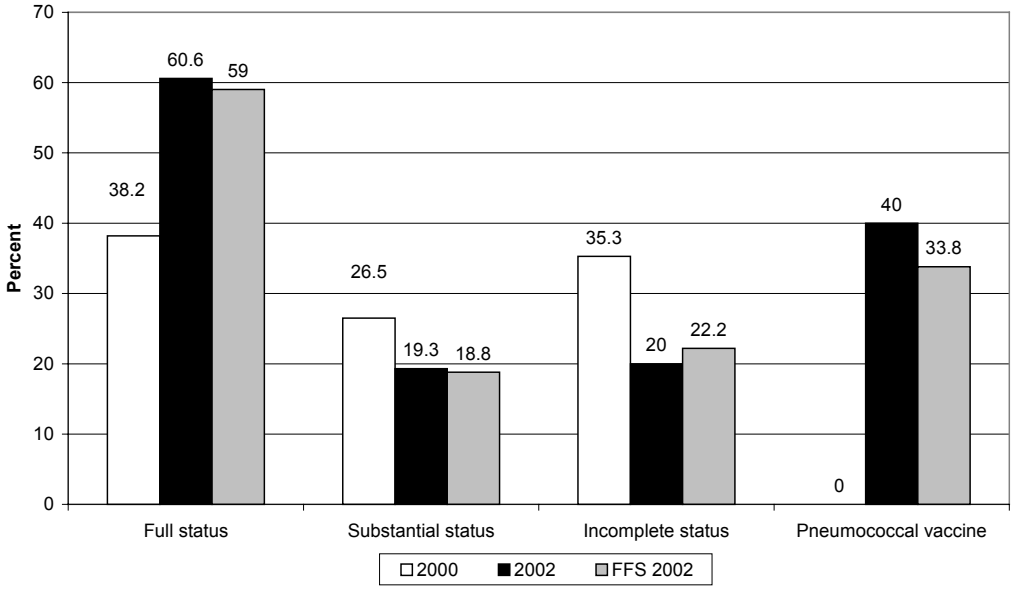
Some conditions may require care or services that cannot be provided on an ambulatory or outpatient basis. Those conditions may require hospitalization, referred to as inpatient care.

Inpatient care may be necessary for many different conditions. For the purposes of the Medicaid/BadgerCare HMO performance monitoring program, five general categories of care are used: maternity, surgery, medical, psychiatric and substance abuse.

This monitoring measure is useful as a tool in assessing access and utilization of inpatient care services. By itself, this measure is not an all-inclusive indicator of sufficiency of access to services, or of appropriateness of care. However, when used in conjunction with other data such as satisfaction, grievance and appeal data, outpatient care data and other measures, it provides a reasonable basis for assessment of overall service delivery.

Immunizations for children

Targeted performance improvement measure



Achieving "full" immunization status as defined by the Centers for Disease Control and Prevention (CDC) can protect young children from ten potentially serious infectious diseases.

Immunization is believed to be one of the safest and most effective health interventions available.

MEDDIC-MS measures the percentage of children enrolled in Medicaid/BadgerCare HMOs who have achieved full immunization status, substantial (partial) immunization status and who have incomplete or inadequate immunization status. The rate of administration of the multivalent pneumococcal vaccine is included as a monitoring measure as it is a relatively new vaccine. Substantial status refers to children who have received most but not all of the doses of certain vaccines given in multi-dose series believed necessary to confer substantial immunity.

Fee-for-service data were also calculated using MEDDIC-MS specifications for comparison. In 2002, the rate of full immunization status for children served in the fee-for-service delivery system was only slightly lower than that in the HMO delivery system. However, the denominator for the FFS rate was very small (432) because most children are in the HMO system.

Overall, the rate of full immunization status has increased significantly between 2000 and 2002. Nevertheless, this remains a performance improvement opportunity because the performance rate remains below the national public health goal* of 90 percent as the desired outcome for this indicator. Three HMOs have conducted performance improvement projects on childhood immunization rate improvement since 2000.

**Healthy People 2010.*

Mammography (screening) and malignancy detection

Monitoring measure

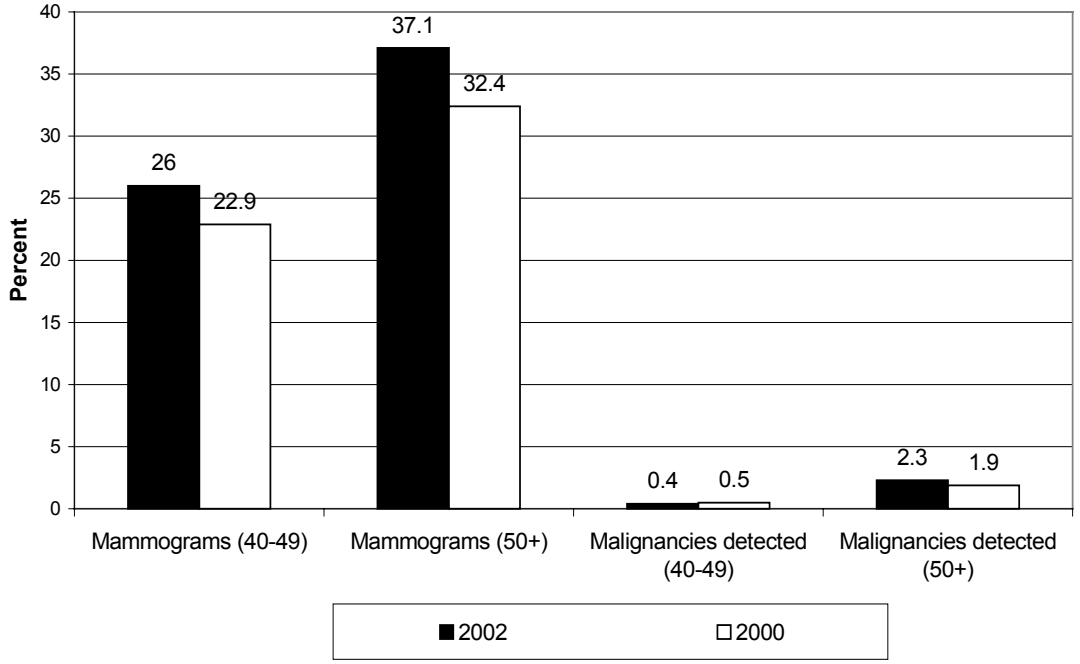
Early detection of breast cancer improves outcomes of treatment and long-term survival.

Mammography is recognized as a highly effective method for early detection of breast cancer.

The American Cancer Society and the National Cancer Institute each recommend that women over age 40 have regular screening mammograms.

Though only 0.3 percent of enrollees in Medicaid/BadgerCare are women over age 40, facilitating and tracking the provision of screening mammography is important because of the benefits of early detection and treatment.

MEDDIC-MS 2002 Mammography and Malignancy Detections compared to MEDDIC-MS 2000



Despite the relatively small population of women enrolled in Medicaid/BadgerCare who fall into the age range targeted for provision of mammograms, the percentage of women in both age groups in the measure who received screening mammograms increased somewhat.

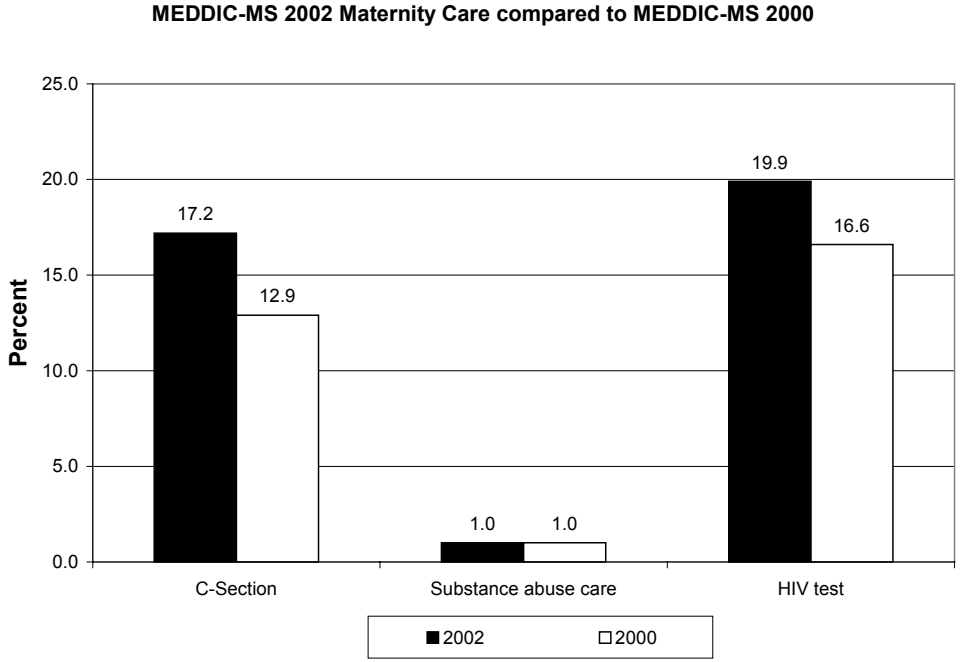
The mammogram rate for ages 40-49 years increased from 22.9 percent in 2000 to 26 percent; the rate for age 50+ years increased from 32.4 percent in 2000 to 37.1 percent in 2002. The outcome measure for this service, detection of breast malignancies, remained stable; 0.5 percent in ages 40-49 years and increased slightly in 50+ years from 1.9 percent in 2000 to 2.3 percent in 2002.

Maternity care

Monitoring measure

Cesarean section (C-section) childbirth may be the safest form of delivery in certain circumstances. However, since C-sections pose risks of their own, the procedure should be used only when it is truly necessary. For these reasons, and the prevalence of women of child-bearing age in Medicaid/BadgerCare, tracking the use of the procedure is of particular importance.

Provision of other health care services in the perinatal period may be of very high importance to the health of both mother and child. Two services that are monitored in the MEDDIC-MS measure set are provision of substance abuse services and voluntary HIV screening tests.



A possible performance improvement opportunity exists in the area of maternity care, particularly births by Cesarean section. The rate of births by C-section increased from 12.9 percent in 2000 to 17.2 percent in 2002. However, this data must be viewed in the context of a recently reported national trend toward increased use of C-sections. According to the Centers for Disease Control and Prevention, the national rate has increased to 24.4 percent of all births.

Provision of substance abuse care in the perinatal period remained stable at about 1.0 percent and provision of HIV screening increased from 16.6 percent to 19.9 percent.

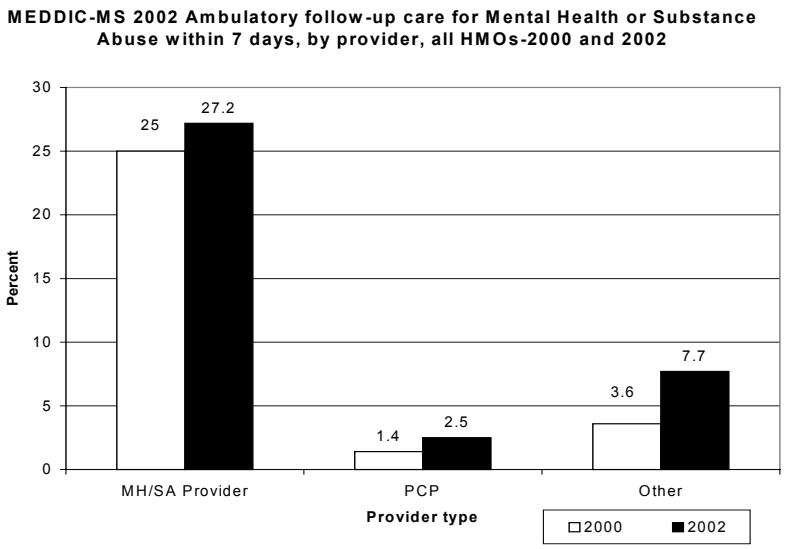
Mental health/substance abuse (MH/SA) follow-up care within 7 and 30 days of inpatient discharge

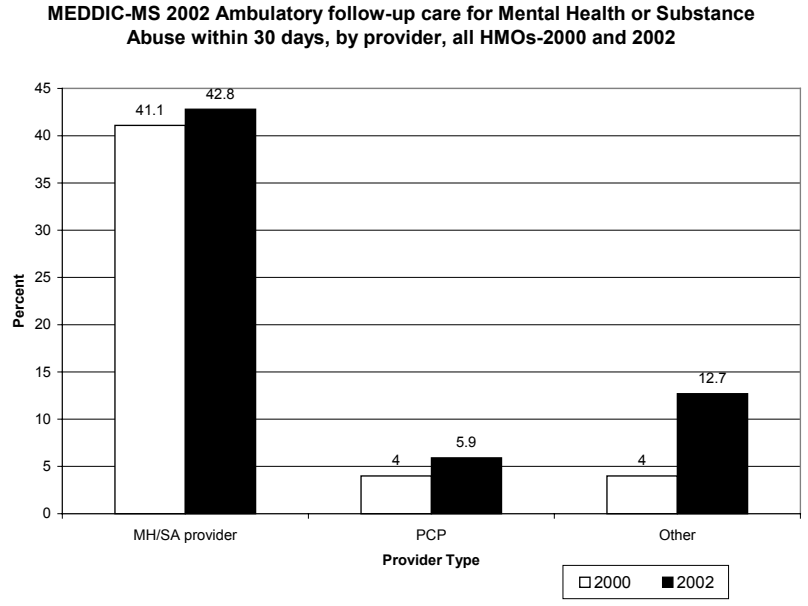
Targeted Performance Improvement Measure

Research has shown that follow-up care on an outpatient basis for individuals who have had inpatient care for mental illness or substance abuse is effective in reducing readmission to the inpatient setting for the same diagnosis.[1]

The MEDDIC-MS measure set evaluates provision of follow-up care by both specialty care providers and primary care providers (PCP) as well as outpatient care provided within 7 days of discharge and within 30 days of discharge. For instances when appropriate service codes appear on encounter records but the provider type is not specified, the services are included in the category "other" to avoid underreporting.

Overall, access to follow-up care, as indicated by utilization data, by all providers increased from 2000 to 2002.

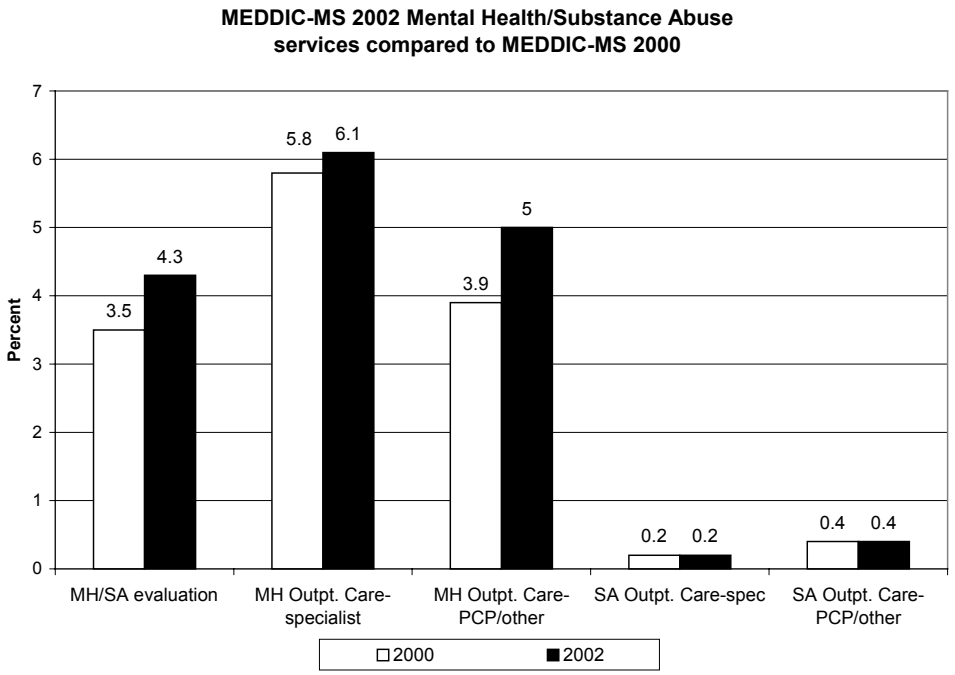




[1] *Evaluation and the Health Professions, Special Edition, State Medicaid Quality Programs*, "Outpatient Utilization Patterns and Quality Outcomes after First Acute Episode of Mental Health Hospitalization," Delmarva Foundation, December 2000.

Mental health/substance abuse-evaluations and outpatient care

Monitoring Measure



The first step in access to mental health and substance abuse (MH/SA) services is often an evaluation by practitioner who specializes in those areas. The possibility that HMOs inappropriately restrict access to MH/SA evaluation and treatment services is a potential concern in the Medicaid/BadgerCare program. Monitoring the rate of evaluation and treatment services is useful to detect access trends.

Many mental health and substance abuse conditions can be successfully treated on a day treatment or outpatient basis. In addition, most people prefer such treatment to inpatient care. Thus, access to day and outpatient treatment services is both preferred by enrollees and useful to reduce the need for inpatient care. The MEDDIC-MS system also tracks the provision of these services by provider type in order to gain insight into HMO network adequacy. Care by a specialist may be preferable or essential in some instances, however, due to a statewide scarcity of specialists, it may be necessary for primary care providers or even physician extenders to provide services in some cases. This is often appropriate and may be the consumer's choice due to location and trust in the provider.

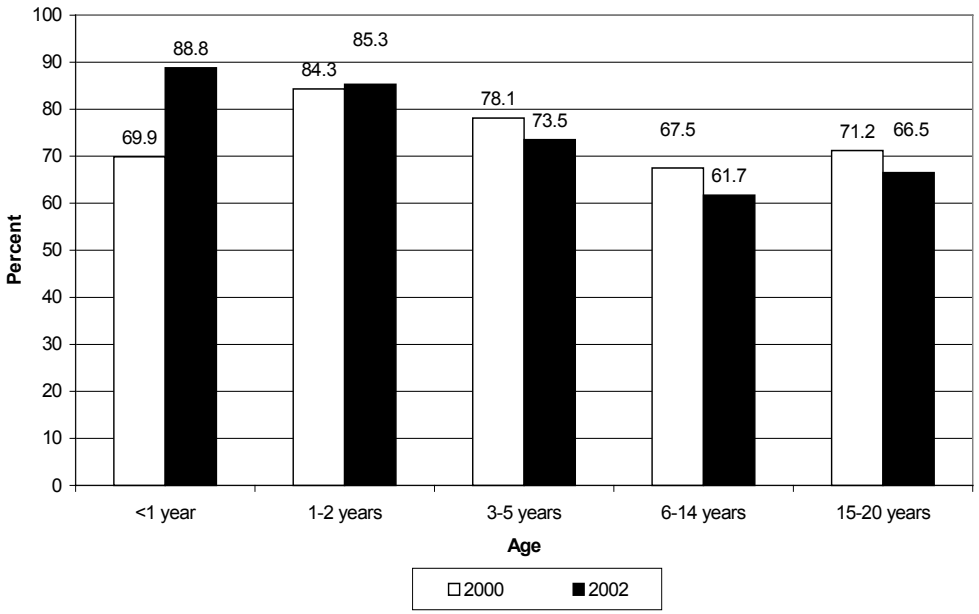
Utilization data indicates that access to outpatient substance abuse care from all provider types was unchanged from 2000 to 2002. Access to outpatient mental health care by all providers increased in the period, as did access to evaluations.

Non-HealthCheck well-child care

Monitoring measure

Non-HealthCheck well-child visits are primary care visits that may be too limited in scope to qualify as "HealthCheck visits," but do result in delivery of some preventive or other health services. A common example of such visits is a postnatal visit for a new mother that is timed to coincide with the due date for immunizations for the child, where the immunizations are given, but may not involve the full HealthCheck exam.

MEDDIC-MS 2002 Non-HealthCheck Well-child visits, all HMOs, Compared to MEDDIC-MS 2000



The positive health and economic effects of well-child services, particularly in early childhood have been demonstrated in a recent study.[2]

The study found:

- California had the highest percentage (30 percent) of children with five or more well-child visits in the two-year study period of the states included, and the lowest rate of avoidable hospitalizations (70/1,000).
- Michigan had the second highest percentage (22 percent) of children with five or more well-child visits in the study period, and the second lowest rate of preventable hospitalizations, (120/1,000).
- Georgia had the lowest percentage (15 percent) of children with five or more well-child visits in the study period and the highest rate of preventable hospitalizations (160.9/1,000).

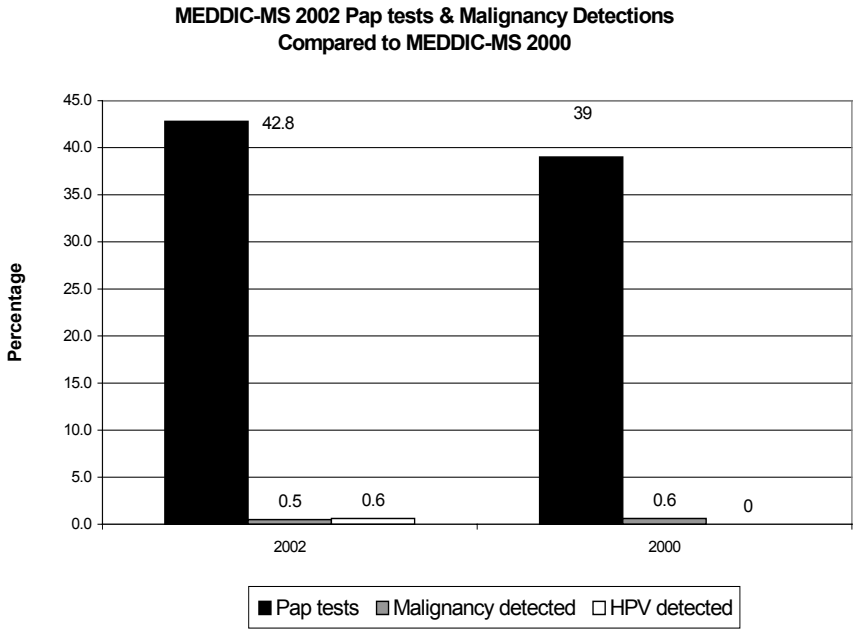
The authors of the study concluded that the "association between preventive care and a reduction in avoidable hospitalizations was robust and was consistent across the states and racial and ethnic groups."

MEDDIC-MS data for children with at least one visit in the look-back period shows improved access among children <1 year of age--which may explain, in part, the increase in childhood immunization rates. However, visit rates in three oldest age groups actually declined somewhat; a trend that may require further study.

[2] *Effectiveness of compliance with pediatric preventive care guidelines among Medicaid beneficiaries*. Hakim RB, Bye BV. July 2001. PEDIATRICS, Vol. 108, No.1:90-97.

Pap tests-cervical cancer screening

Monitoring measure



The majority of Medicaid/BadgerCare enrollees are females and only about 29 percent of the females enrolled are 21 years of age or older. Consequently, women's health services are of particular significance to the Medicaid/BadgerCare program.

Cervical cancer is diagnosed in approximately 15,000 women in the United States each year. According to the Centers for Disease Control (CDC), cervical cancer remains a leading preventable cause of death among women and, after three decades of decline, the mortality rate has begun to rise. Early detection is relatively easy and is the key to a high probability of survival. The most common method for early detection is called the "Pap test."

According to the CDC, Human Papillomavirus (HPV) infection is a causal factor in more than 90 percent of cervical cancers. This measure assesses the detection rates for malignancy and HPV infection.

The Pap test is generally performed every three years, beginning when the woman becomes sexually active or by age 18 years. Thus, the Pap test is not required annually, and the MEDDIC-MS measure is designed to take this into account. The age group for this measure was changed from 19-65 years in 2000 to 18-65 in 2002.

Provision of cervical cancer screening tests (Pap tests) increased from 39 percent to 42.8 percent for women age 18-65 years. Outcome measure results, the rate of detection of malignancy, for this service remained essentially the same; 0.5 percent in 2002 compared to 0.58 percent in 2000. One HMO has conducted a performance improvement project on increasing Pap test rates since 2000.

Results on Non-clinical Performance Measures

Key to HMOs for Individual HMO charts:

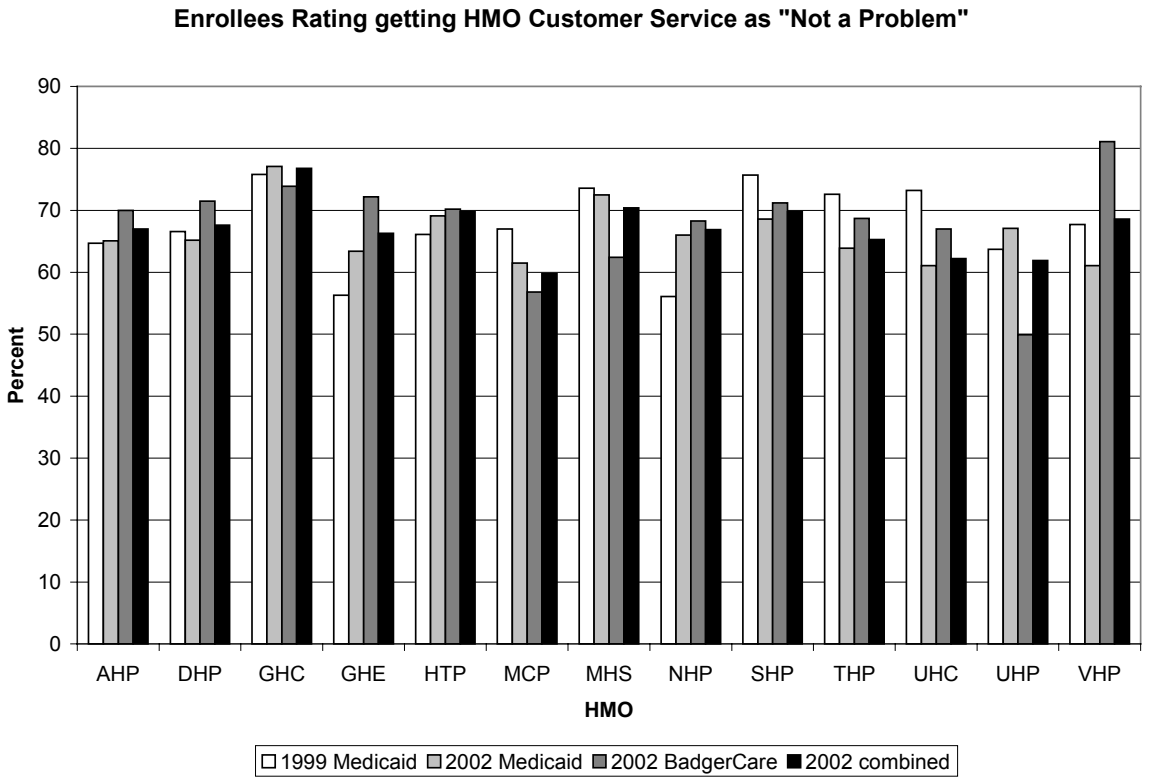
AHP Atrium Health Plan
DHP Dean Health Plan*
GHC Group Health Cooperative-South Central*
GHE Group Health Cooperative-Eau Claire
HTP Health Traditions Health Plan
MCP MercyCare Insurance Corporation*
MHS Managed Health Services
NHP Network Health Plan
SHP Security Health Plan*
THP TouchPoint Health Plan*
UHC United Healthcare*
UHP Unity Health Plans*
VHP Valley Health Plan

*This HMO is fully accredited by the National Committee for Quality Assurance (NCQA®) and has qualified for participation in the Department of Health and Family Services HMO Accreditation Incentive Program.

Note: Five HMOs that were included in the 1999 Medicaid survey no longer participate in Medicaid or BadgerCare. Also, the HMO formerly known as Greater LaCrosse Health Plan is now Health Traditions. The HMO formerly known as Primecare is now known as United Healthcare.

Satisfaction with HMO customer service

CAHPS® satisfaction survey item
Targeted performance improvement measure



HMO customer service was identified as a performance improvement opportunity in the 1999 Medicaid satisfaction survey. As a result, in 2001, this CAHPS® Satisfaction survey indicator was added to the MEDDIC-MS system as a Targeted Performance Improvement indicator.

Six HMOs had improved ratings from survey respondents in 2002 compared to 1999.

Both of the HMOs (Group Health Cooperative-Eau Claire and Network Health Plan) identified in 1999 as having significantly lower than average performance on this indicator exhibited significant improvement in 2002.

Unlike other indicators monitored through the CAHPS® Satisfaction survey, the majority of HMOs earned higher ratings on this indicator from BadgerCare enrollees than from Medicaid enrollees.

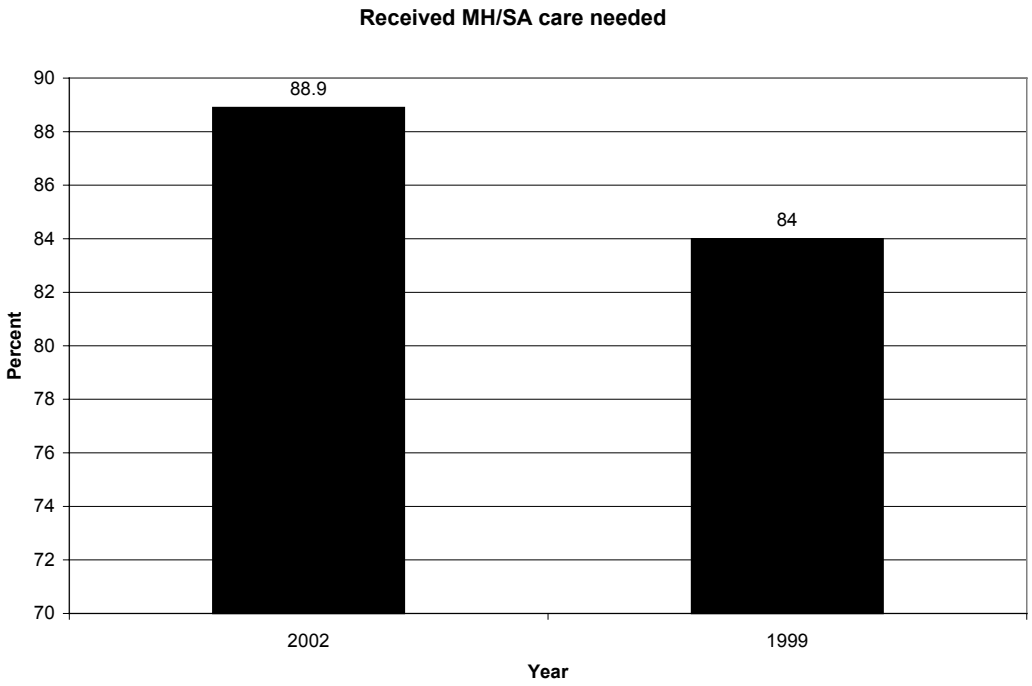
Group Health Cooperative-South Central had the highest combined satisfaction rating on this indicator; MercyCare Insurance Corporation had the lowest combined rating.

This indicator will continue to be monitored as a measure in the MEDDIC-MS system.

NOTE: Please refer to the Key to HMOs on page 25 for HMO name abbreviations.

Satisfaction with receiving mental health/substance abuse (MH/SA) care

CAHPS® satisfaction survey item
Targeted performance improvement measure



Mental illness can affect people of all ages and backgrounds. It can occur alone but may also occur concurrently with other physical health or substance abuse problems. Access to mental health (MH) and substance abuse (SA) services is a vital part of an effective health care system.

In order to augment clinical measures of access to mental health and substance abuse care, the MEDDIC-MS system includes a measure of enrollee satisfaction with access to those services that are part of the state's CAHPS® Enrollee Satisfaction Survey.

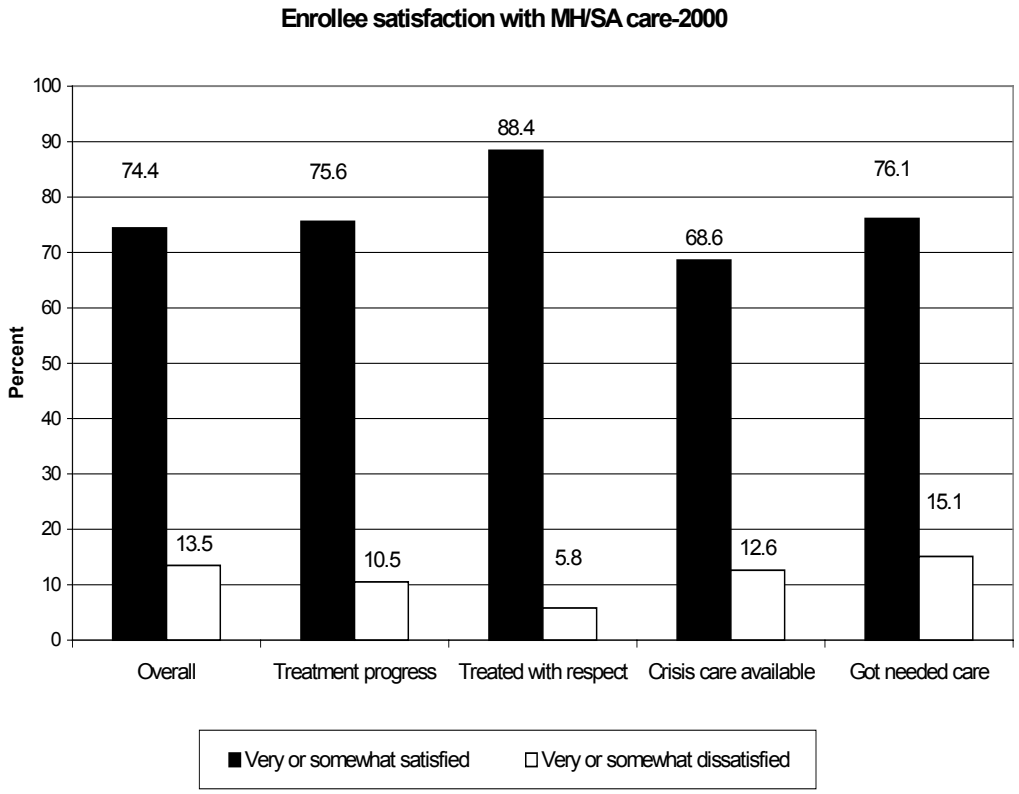
The survey questions used in 1999 and 2002 were somewhat different, but both asked enrollees to rate their satisfaction with access to mental health and substance abuse services. The 1999 question asked enrollees whether they got the MH/SA care they felt they needed and to give a "yes" or "no" response. The 2002 question asked enrollees to rate getting MH/SA care they felt they needed on whether getting that care was "no problem," a "small problem," or a "big problem." This chart compares the percentage of "yes" responses from the 1999 survey to the percentage of "no problem" and "small problem" responses from the 2002 survey.

Because the two charts display responses to a slightly different type of question, comparison must be made cautiously. There was an increase in satisfaction on this indicator from 1999 (84 percent) to 2002 (88.9 percent). Overall access to MH/SA services must be assessed using a combination of the clinical and non-clinical measures in the MEDDIC-MS system. Future CAHPS® satisfaction survey questions on this topic will not be changed from the 2002 survey to allow direct comparison.

Satisfaction with mental health/substance abuse (MH/SA) care

State-specific satisfaction survey item

In 2000, the department conducted additional survey activity in an effort to "drill down" to more specific levels of detail in the area of mental health and substance abuse services. Though the measures included in this survey are not specifically included in the MEDDIC-MS measure set, the data is included in this report for the purpose of allowing more complete analysis of the HMO program performance in the areas of mental health and substance abuse care.



The survey specified by the state asked enrollees who had recently received mental health or substance abuse services about their experience of care with those services. This chart illustrates some of the results on key items.

Overall satisfaction with mental health and substance abuse services was quite high with three out of four respondents indicating they were either "very" or "somewhat" satisfied with services. Respondents indicated satisfaction with the progress of their treatment and with ability to get the care they needed by a nearly identical margin. Only 13.5 percent of respondents were very or somewhat dissatisfied overall and only 10.5 percent indicated they were very or somewhat dissatisfied with their treatment progress.

Access to care did not appear to be a major obstacle, with eight out of ten respondents indicating they could get an appointment when they wanted one.

Analysis of performance improvement opportunities and strategic implications

Calendar year 2002 data on clinical and non-clinical performance indicators revealed improvement in overall HMO program performance. Quality improvement strategies implemented over the past several years appear to have had a positive effect in several priority areas being monitored. Areas where combined efforts of the state and participating Medicaid/BadgerCare HMOs have been brought to bear appear to have improved.

For example, emergency department and inpatient care utilization for asthma declined from 2000 to 2002, even though disease prevalence was unchanged. The Department has operated a Care Analysis Project (CAP) on asthma since 2001, 9 of 13 HMOs responding to a recent survey indicated that the HMO has a disease management program for asthma and 7 of 13 HMOs have conducted performance improvement projects on the subject since 2000. The presence of asthma as a topic in the MEDDIC-MS measure set also has contributed to heightened awareness among HMOs of the need for improved performance.

In addition, improvements in provision of diabetes management services occurred between 2000 and 2002. As with asthma, diabetes has been included in the Care Analysis Project since 2001, and has been the subject of four HMOs' performance improvement projects since 2000. In addition, 10 of 13 HMOs have disease management programs for diabetes. These combined approaches appear to be effective strategies in improving quality of care even in areas of care that have been historically difficult to influence.

These combined efforts have contributed to better identification, outreach and ambulatory care for individuals with asthma and diabetes, though the exact contribution of each approach cannot be quantified. These findings suggest several strategy options for further quality performance improvement program-wide. They include:

- Broaden the Care Analysis Project to include additional topics--childhood immunizations and Pap tests, for example.
- Encourage all HMOs to develop disease management programs for asthma, diabetes and other chronic conditions that respond to disease management.
- Consider options to increase the number and effectiveness of HMO performance improvement projects.
- Improve early identification of enrollees with special health care needs. This strategy has been partially implemented with the introduction of the New Enrollee Health Needs Assessment in January 2003.
- Develop strategies to improve access to primary care. This is being addressed with an effort to develop a primary care access incentive program.

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